MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF NOVEMBER 10, 2010

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

THE PUBLIC HEALTH COUNCIL OF
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Henry I. Bowditch Public Health Council Room, 2nd Floor
250 Washington Street, Boston, MA

Updated Docket: Wednesday, November 10, 2010, 9:00 AM

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1. ROUTINE ITEMS: No Floor Discussion

a. Compliance with Massachusetts General Laws, Chapter 30A, §11A ½ **(No Vote)**

b. Records of the Public Health Council Meeting of August 11, 2010 **(Approved)** and September 8, 2010 **(Approved)**

2. PROPOSED REGULATION: No Floor Discussion/Information Only (No Vote)

Informational Briefing on Proposed Amendments to 105 CMR 700.000, Implementation of M.G.L. c. 94C Concerning Nurse Anesthetists

3. REGULATION: No Floor Discussion

Request for Final Promulgation of Emergency Amendments to 105 CMR 170.000, Emergency Medical Services System, Regarding Paramedic Staffing **(Approved)**

4. DETERMINATION OF NEED PROGRAM: BULLETIN OF ANNUAL ADJUSTMENTS TO DoN EXPENDITURE MINIMUMS

Request for Approval of Informational Bulletin on Annual Adjustments to Determination of Need Expenditure Minimums **(Approved)**

5. PRESENTATION: No Vote/Information Only

"Hospital Personnel Seasonal Influenza Vaccination Report, 2009-2010"

6. PRESENTATION: No Vote/Information Only

"New DPH Initiative to Promote Regional Delivery of Local Public Health"

The Commissioner and the Public Health Council are defined by law as constituting the Department of Public Health. The Council has one regular meeting per month. These meetings are open to public attendance except when the Council meets in Executive Session. The Council's meetings are not hearings, nor do members of the public have a right to speak or address the Council. The docket will indicate whether or not floor discussions are anticipated. For purposes of fairness since the regular meeting is not a hearing and is not advertised as such, presentations from the floor may require delaying a decision until a subsequent meeting.

PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council (M.G.L.c17,§§1,3) was held on November 10, 2010, 9:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Henry I. Bowditch Public Health Council Room, 2nd Floor, Boston, Massachusetts 02108. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen Caulton-Harris, Dr. John Cunningham, Dr. Muriel Gillick, Mr. Paul Lanzikos, Ms. Lucilia Prates Ramos, Mr. Josè Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman, Dr. Michael Wong, and Dr. Alan C. Woodward. Absent members were: Mr. Harold Cox, Dr. Michèle David, Mr. Denis Leary, and Dr. Barry Zuckerman. Also in attendance was Attorney Donna Levin, General Counsel, Massachusetts Department of Public Health.

Chair Auerbach announced that notice of the meeting has been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. Chair Auerbach made introductory remarks and noted (1) that the December meeting has been rescheduled from December 08 to December 15, 2010 and (2) that Harold Cox has been re-appointed to the Public Health Council.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF AUGUST 11, 2010 AND SEPTEMBER 8, 2010:

Council Member Josè Rafael Rivera made a motion to accept the August 11, 2010 minutes as presented. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the minutes of August 11, 2010 as presented.

Council Member Helen Caulton-Harris made a motion to accept the September 8, 2010 minutes as presented. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the minutes of September 8, 2010 as presented.

PROPOSED REGULATION:

Dr. Grant Carrow, Director, Drug Control Program, Department of Public Health, presented information on proposed amendments to 105 CMR 700.000 that confer prescriptive authority on nurse anesthetists. He noted that Attorney Howard Saxner, Deputy General Counsel, worked on the proposed regulations but was unable to attend the meeting. Dr. Carrow highlighted the proposed changes to the regulations which were signed into law by Governor Patrick as Chapter 191 of the Acts of 2010. The act amends both the Controlled Substances Act governed by the DPH and the Nursing Licensing Commission governed by the Board of Registration in Nursing. He said the law is "intended to improve patient care, health and safety, and reduce medication errors and adverse effects, as well as hold down health care costs."

Dr. Carrow noted that the Act requires the Commissioner of the Department of Public Health to promulgate rules and regulations to provide the prescriptive authority to nurse anesthetists. He explained that nurse anesthetists are advanced practice nurses who administer anesthesia in surgery and practice in many settings such as hospitals, ambulatory surgical centers, office settings including dioptry, plastic surgery and dentistry. He indicated that there are about 1100 nurse anesthetists in Massachusetts and 28 other states allow prescriptive authority for nurse anesthetists.

Dr. Carrow said in part, "…The mutually built guidelines with the supervising physicians would establish the scope of the practice for the nurse anesthetists. The Board of Nursing Regulations would define the scope of practice for the nurse anesthetists, require them to have the appropriate training and experience, and specify the requirements for the guidelines developed with the supervising physician. The Board of Medicine Regulations would…set the requirements for the physician supervision, as well as address the issues in regard to the guidelines between the two practitioners."

He continued, "In terms of the regulations before your today, they would be very similar to those for other advanced practice nurses already in effect, which would include the requirement for nurse anesthetists to meet the board's requirements, to register with DEA, to have the written guidelines as outlined before, to prescribe within the scope of practice. It specifies the requirements for ordering medications and for dispensing them for immediate treatment and for samples. It also specifies requirements for oral prescribing and for making medication orders in health care facilities…"

He noted some additional house-keeping changes have been made to the regulations: adopting the statutory definition of written prescriptions, extend the record-keeping requirements to pharmacists with prescriptive authority that was missing from the previous amendments, extend the requirement for optometrists to get separate registrations for separate activities, corrections to names for the DEA, the Department of Public Health and the new name for the Department of Developmental Services, remove "certified" as a qualifier for nurse midwife because the regulations already require them to be registered nurses and repeal the requirements for purchase of hypodermic instruments because of the deregulation of syringes and needles a few years ago.

It was noted that a public hearing will be held jointly with the Board of Registration in Nursing, probably in December and then they will return to the Council with the final proposed regulations for approval in early 2011. Dr. Carrow noted that the Board of Medicine will not be amending its regulations because the Board has determined that its present regulations cover nurse anesthetists and other advanced practice nurses sufficiently.

Discussion followed by the Council. Please see the verbatim transcript for full discussion. Dr. Alan Woodward asked for clarification on what the Board of Medicine Regulations allows for "the supervising physician". Would the supervising physician have to be an anesthesiologist or any physician? Dr. Carrow said he would follow up with the Board of Medicine and find out. Dr. Carrow said that the scope of practice between the supervising physician and

nurse anesthetist has to coincide as it is for any advanced practice nurse. Dr. Woodward said he is concerned if they are allowing any supervising physician. Chair Auerbach noted that Dr. Carrow could get the answer in writing and have the Public Health Council Secretary email it to the Council. Chair Auerbach asked Dr. Carrow to have that discussion with the Board of Medicine and Board of Nursing and get back to the Council with the information before the regulations return for final vote to the Council. Dr. Woodward stated that if the language isn't there, it needs to be addressed.

During discussion Dr. Michael Wong asked what the prescribing limitations are on the nurse anesthetist. Dr. Grant noted on pages 10 and 11 of the Board of Registration in Nursing's Proposed Regulations it states the "nurse anesthetist may engage in activities accordance with guidelines developed with the supervising physician … and in terms of prescribing, it states "for immediate peri-operative care, as authorized under the guidelines developed with the supervising physician…"

Chair Auerbach noted that staff can ask the questions of the Boards, give the information to the Council in writing, include the information in the summary discussion when this is before the Council again and further that they will be sure to have representatives from both Boards present. Dr. Carrow noted for the record, "I would like to emphasize that it is not the Drug Control Program's jurisdiction to determine what the scope of practice of nurse anesthetists is or the supervising physician but to confer prescriptive authority once those boards have said that they are qualified to engage in this activity."

NO VOTE/INFORMATION ONLY

REQUEST FOR FINAL PROMULGATION OF EMERGENCY AMENDMENTS TO 105 CMR 170.000 EMERGENCY MEDICAL SERVICES SYSTEM, REGARDING PARAMEDIC STAFFING:

Chair Auerbach explained to the Council that they will be hearing about the public hearing public comment period and be making a final decision on these regulations by voting to make them become permanent regulations and not emergency regulations.

Mr. Abdullah Rehayem, Director, Office of Emergency Medical Services, accompanied by Attorney Carol Balulescu, Deputy General Counsel, presented the final regulations to the Council. Mr. Rehayem stated in part, "…As you know, the Governor passed the Emergency Relief Act on July 27th, accompanied by an emergency letter signed by the Governor. The new Act added a staffing standard to the EMS law, which did not have a staffing standard in EMS law, and the standard called for, when a patient is being treated at the paramedic level, the ambulance must be staffed with two EMTs, one of whom must be a paramedic, in accordance with regulations promulgated by the Department…Based on the directives of the law, the Department amended the regulatory staffing standards that we have to specify standardized conditions to protect the public health and safety. The conditions that are in the draft regulations are from guidelines, administrative requirements that were already in place for ambulance services operating with one paramedic and one basic EMT when they wish to treat the patient at the paramedic level. These standards were not new…"

Mr. Rehayem spoke about the public comments which are summarized in the memorandum to the Public Health Council, dated November 10, 2010. As a result of the public comments, three changes were made to the draft regulations: staff clarified what was meant by Emergency Medical Dispatch and stated that Emergency Medical Dispatch must be done in accordance with a State 911 Department; secondly staff changed the language about the dispatch of a second paramedic – instead of stating "in a timely manner", staff changed that language to indicate that a second paramedic, when

needed, must be immediately dispatched; and thirdly, staff further clarified that paramedic ambulance services must conduct quality assurance and quality improvement measures.

Discussion followed by the Council. Please see verbatim transcript for full discussion. Dr. Alan Woodward noted that Basic EMTs have about 110 hours of training and Paramedics have about 2,000 hours of training and thus are not comparable. He said in part "…though it is potentially more cost effective, it is a balance here between cost and quality…it is clearly going to be a different standard and I think we will end up with some increased disparities because municipal large cities are always going to have two paramedic ambulances…When a call is a major motor vehicle accident or someone in cardiac arrest, there ought to be two paramedics dispatched…it is going to be incumbent upon the Department to deliver these administrative requirements and look at the effects of this change, and have a quality feedback system so that, if we see that we are having negative outcomes or reduced outcomes as a result of this, that we have mechanisms to go back and look at how we can tighten it up…" Dr. Woodward further noted that it requires a population of 150,000 to support an ALS service so maybe this will drive regionalization and regional dispatch.

Mr. Abdullah Rehayem responded that the guidelines will be developed with guidance from the clinical community, the emergency physicians and trauma experts. The Department will receive feedback from the Medical Services Committee of the Emergency Medical Advisory Board which is staffed by all five regional medical directors. He indicated that the guidelines are statewide and some people want them to be more restrictive and others want them to be lenient and the Department will have to find a middle ground.

Mr. Albert Sherman moved approval of the regulations. After consideration, upon motion made and duly seconded, it was voted unanimously to approve **the Final Promulgation of Emergency Amendments to 105 CMR 170.000, Emergency Medical Services System, Regarding Paramedic Staffing**. A copy is

attached and made a part of this record as **Exhibit Number 14,964.**

Chair Auerbach suggested that Dr. Woodward review the guidelines and provide feedback to the Department because of his expertise and knowledge of the subject matter.

DETERMINATION OF NEED PROGRAM: BULLETIN OF ANNUAL ADJUSTMENTS TO DON EXPENDITURE MINIMUMS:

Ms. Joan Gorga, Director, Determination of Need Program, presented the Bulletin to the Council. She said in part, "…I am here to request the adoption of the annual Informational Bulletin that establishes the Determination of Need expenditure minimums. The minimums are increased each year using two indices: Marshall & Swift Valuation Service for capital costs and Global Insight and Health Care Cost Review for operating costs… Exhibit A shows the calculations used and Exhibit B shows the results which were used for the filing year which began on October 1, 2010. Projects with a dollar value below these minimums do not require filing a DoN application. You may recall that last year, with the changes in the economy, the indices exhibited deflation rather than inflation, and the expenditure minimums decreased rather than increased. That was the first time in the history of these indices that that had happened. The decrease has been reversed this year, and the expenditure minimums are slightly higher than they were in 2008 before the decline. Staff asks that you adopt the Informational Bulletin and the Expenditure Minimums for the next year."

Dr. Michael Wong moved approval of the Bulletin. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the Determination of Need Program's **Informational Bulletin of Annual Adjustments to DoN Expenditure Minimums** as presented to the Council in staff's Memorandum dated November 10, 2010. These figures are effective as of October 1, 2010 per Determination of Need Regulations. The capital cost figure is 1.0655 and for operating costs 1.017. Annual Adjustments to DoN Expenditure Minimums Follow:

Capital Expenditures

Project type	October 1, 2009	Filing Year Beginning October 1, 2010
Equipment for non-acute facilities and clinics	$781,221	$832,391
Total capital expenditure including equipment for non-acute care facilities	$1,562,445	$1,664,785
Capital expenditure, excluding major movable equipment, for acute care facilities and comprehensive cancer centers	$14,647,931	$15,607,370
Outpatient service expenditures and acquisitions other than new technology or innovative services	$23,891,293	$25,456,173

Operating Costs

Project Type	October 1, 2009	Filing Year Beginning October 1, 2010
Nursing, Rest Homes and Clinics	$740,042	$752,623

PRESENTATION: "HOSPITAL PERSONNEL SEASONAL INFLUENZA VACCINATION REPORT, 2009-2010":

Dr. Alfred DeMaria, Medical Director, Bureau of Infectious Disease, accompanied by Eileen McHale, Health Care Associated Infection Coordinator, presented an update on the first year of findings for hospitals vaccinating their staff for seasonal flu vaccine.

Dr. DeMaria noted that the Department hopes that all hospital personnel will get vaccinated including contracted workers, volunteers and students, anyone who works in the facility. He noted that historically the numbers have been low for this population but

that the figures are improving. This data is self reported data. He said in part, "…We asked for an estimate of all personnel as of August 1, 2009 and those vaccinated from September through March. For this season, 71 out of 71 acute care hospitals submitted data." Dr. DeMaria noted that the average vaccination rate for hospital personnel was 68%, compared with 51% from the previous year. Fifty-four percent were vaccinated at the hospital and 10% were vaccinated outside the hospital. Sixteen percent of the hospitals had no change or went down which may be because of the denominator used, the availability of the vaccine and how aggressively they pursued information about vaccination at the site. DPH's Public Health Hospitals had 72% compliancy.

Discussion followed. Please see verbatim transcript for full discussion. Ms. McHale clarified that for the upcoming reporting year the denominator will be employees on the payroll as of December 31, 2011 and she noted that they have expanded their reporting requirements to include clinics, dialysis centers and long term care facilities.

Dr. DeMaria noted, "This is a health care worker welfare issue. This should be part of our occupational health program to protect health care workers from influenza. Secondly, it is obviously a patient safety issue that protects patients from exposure to influenza from their care givers. It is two-fold and all of the major organizations now have not only supported health care worker immunization with flu vaccine for many years, but now most of the major national infection control and infectious disease professional societies have recommended mandatory condition of employment, and a number of hospitals, hospital systems have implemented that for the past years, and I think that is something that has been suggested to the Department."

Chair Auerbach stated, "I want to emphasize very strongly that we, the Council passed a regulation with the intent of which was, 100% vaccination or 100% indication of declination…This is part of the licensure requirement. This is not an option or just a recommendation… Short of mandating, we were saying, if we are not

going to mandate then you simply either have to offer it to everybody or your people could decline…My own recommendation is we should notify every single hospital of what the regulatory requirements are and of our intent to insist that the regulation is complied with…for the ones that didn't comply we should say unacceptable and that the expectation is that people take every opportunity to go along with the regulations."

Discussion continued and Dr. Meredith Rosenthal said in part, "…Why do some hospitals have lower rates than others? Denial may be reversible…What can we do about that and I wonder if there isn't some way that we can do more than report because I think it is important …What might we do to support volume here?"

Dr. DeMaria responded in part, "…The hospitals that did very well took every opportunity to vaccinate. In every meeting in that hospital, somebody was there to vaccinate. Whether it was an administrative meeting, grand rounds, lunch, they just showed up with the capacity to vaccinate…with public reporting as an incentive now there is this transparency."

Dr. Muriel Gillick spoke about as a physician having admitting privileges at many facilities and being asked by some of them of her flu shot status but not others. And on the other hand, how many institutions should she have to report this too? Staff noted this is why they changed the definition to employees on payroll. Ms. Caulton-Harris asked, "Is there data around health care worker absenteeism due to influenza in place so hospitals recognize that for them there is an economic impact of not following through and immunizing their workforce?" Dr. DeMaria noted that there are studies done that demonstrate that vaccinating healthy young workers reduces absenteeism and increases productivity but not so many in the health care settings…and that is our goal to demonstrate that health care workers are healthier and patients are healthier…we really need to prove that this is clearly working for the health care worker." Dr. Alan Woodward added in part… "The good news is, we are doing better. The bad news is, we can do better."

Chair Auerbach noted action steps to be taken: (1) improve methodologies so we are more confident that the numbers are consistent and capturing what we want (2) make the information available by hospital to the public/media creating pressure for the lower point hospitals to try to get their numbers up (3) Dr. DeMaria, the Commissioner and perhaps MHA put together a letter for those in violation to put them on notice that the Department may act on this and sent it to the CEOs, Patient Family Councils, and Board Chairs and (4) provide education highlighting best practices in consultation with MHA.

NO VOTE/INFORMATION ONLY

PRESENTATION: "NEW DPH INITIATIVE TO PROMOTE REGIONAL DELIVERY OF LOCAL PUBLIC HEALTH":

Mr. Geoff Wilkinson, Senior Policy Advisor, Commissioner's Office, DPH, presented information on the Department's regional initiative, involving from a federal grant from the CDC, part of the Health Care Reform Initiative that provides financial incentives to create public health regions in Massachusetts. Some highlights from his presentation follow:

"The program is structured as a five-year award with two components. We were eligible for $300,000 dollars a year for five years in Component I and that is basically to put performance management approaches within jurisdictions, to try to get health systems better able to drive policy and address winnable battles, and to help health systems become ready for national accreditation, which is coming."

"Component II, which is where most of the money is, was a competitive program. We were eligible, or allowed to apply for as much as 2.7 million per year for five years, and we did at DPH and there was a lot of latitude but also a fair number of requirements by CDC. CDC was trying to drive these policies and winnable battle changes. Our award is for almost ten million dollars over five years. We have 1.96 million per year, 1.66 million in Component II, and I

am about to describe what is in Component II, but this required us to cut a million dollars a year out of our proposed budget and we actually did not have that funded, so it took a lot of elbow grease to go back and figure out, what are we going to pull out of what we proposed to CDC. The good news is we received the highest award for Component II in the nation. There are some jurisdictions that are larger by populations, that got larger Component I awards, but we did very well nationally, and there were only 14 states that received Component II grants."

Mr. Wilkinson described how the new funding would be allocated, with more than half of the money going into a district incentive grant program and the creation of an Office of Local Health in the Department. The rest of the funding will improve three data systems that provide core infrastructure for Public Health at all levels in the State, and upon which Local Public Health depends: (1) MAVEN (2) MassCHIP, and (3) Vital Records.

"On the data systems, we have the MAVEN system, which is a web-based disease surveillance and disease management system that allows DPH to communicate directly with Clinicians and local public health, and hospitals, in sharing disease reports, lab results, and clinical data for rapid surveillance and response to TB, vaccine preventable diseases, food-borne illnesses, chronic diseases, and we are currently in 187 communities, about 53% of the municipalities. The grand goal is to take this to 95% of communities over the next couple of years, and we, in making the cuts that I mentioned to between what we receive and what we ask for, we are still trying to stay on track with this goal. We will be adding the HIV/AIDS system to MAVEN in 2013 if all goes well."

With the Vital Records, we are in a paper-based system now for death records, which means that it takes six to nine months for us to be able to aggregate and report death records, and that holds up a whole lot of work, including in emergency situations. The goal is to get the death records onto the web, to have real time reporting of deaths and local health is looking forward to this as well…For MassCHIP, we will be bringing this fully onto a web-based platform.

There are lots of user friendly interfaces and statistical methods that are going to be embedded into it, to improve MassCHIP."

"This grant program will hopefully allow us to improve the scope of quality of public health services, reduce some of the regional disparities they currently have in cities and towns without any services, strengthen work force qualifications because we are going to be able to provide money for cities and towns to come together and hire professional staff. We are going to try to cover the largest land area possible, the largest percent of population and the largest number of cities and towns, and we will try to help localities prepare for accreditation, as well, which is going to start being implemented later next year by the Public Health Accreditation Board."

Mr. Wilkinson noted that staff is currently drafting the Request for Response that communities can respond to for funding. The RFR requires communities to: have joint governance while retaining local board of health authority; conduct community health assessments, join MAVEN, inspect their food establishments twice a year, address one of the winnable battles of health such as tobacco or obesity.

In closing, Mr. Wilkinson stated, "…We are waiting for CDC to approve the proposed budget decisions. We are talking with our partners, preparing to engage contractors for the data systems, as well as regionalization, and hope to roll this out very soon…"

Discussion followed by the Council. Please see the verbatim transcript for the full presentation and discussion. Chair Auerbach noted that they didn't want to be too prescriptive on an ultimate goal for regionalization at this point but rather have the involvement of each of the local communities in determining how best to share resources in an efficient manner…Mr. Wilkinson noted further that the Department will be rolling out this grant proposal with cooperation from the Massachusetts Municipal Association (MMA) and said…"They see this as a cooperative opportunity. This brings tensions with the Public Health Community because Boards of Health have experienced, over the last year, consolidation and cuts, and significant reorganizations of the Public Health services by, driven by

municipal officials and in some cases, without consultation with Boards of Health. There are some interesting tensions within all of this and we are trying to negotiate those waters carefully as we roll out this program."

No Vote Information Only

Follow-up Action Steps:

- Follow-up with the Board of Medicine on Dr. Woodward's questions on the meaning of "supervising physician". See page 5 of these minutes for more detail. (Woodward to Carrow) Give an answer to the PHC in writing before this item returns to the PHC and provide a summary on this information when these regulations return to the Council. Linda Hopkins can email the written answer to the Council.
- Invite the Board of Registration in Medicine and Board of Registration in Nursing to the PHC when the Nurse Anesthetists amendments return to the Council. See page 6 of these minutes for more detail. (Auerbach to Carrow)
- Have Dr. Woodward Review the guidelines on Paramedic Staffing for the OEMS so he can provide the Department with his feedback on the matter. (Auerbach to Woodward and Rehayem)
- Notify every single hospital of what the regulatory requirements are on employee influenza vaccinations and the Department's intent to insist that the regulation is complied with. (Auerbach to DeMaria, McHale)
- Regarding Influenza Vaccination Reporting: (1) Improve methodologies, (2) make the information available by hospital to the public and media (3) Dr. DeMaria, Auerbach and perhaps MHA put together a letter for those in violation of the law and sent it to CEOs, Patient Family Councils and Board Chairs and (4) provide education by highlighting best practices in consultation with MHA. (Auerbach to DeMaria, McHale) See page 13 of these minutes for more detail.

List of Documents Presented to the PHC for this Meeting:

- Docket of the meeting
- Copy of the meeting notice to A&F and Secretary of the Commonwealth
- Minutes of the Meetings of August 11 and September 8, 2010
- Staff's Memorandum to the Council dated November 10, 2010 on Proposed Amendments to Regulations 105 CMR 700.000 (Implementation of the Controlled Substances Act Regarding Nurse Anesthetists) with Attachment A (proposed changes to the regulations) and Attachment B (final regulations with proposed changes) and a copy of the PowerPoint Slide Presentation
- Copy of the 244 CMR 4.00: Massachusetts Regulations Governing the Practice of Nursing in the Expanded Role, pages 1-12 with an effective date of 3/11/94
- Copy of 243 CMR: Board of Registration in Medicine Regulations, pages 35 and 36 (2.09, 2.10, 2.11) with effective date of 12/1/93
- Staff's Memorandum dated November 10, 2010 on the Request for Final Promulgation of Emergency Amendments to 105 CMR 170.000, Emergency Medical Services System, Regarding Paramedic Staffing, and Attachment I (proposed changes to the regulations) and Attachment II (Testimony Regarding Emergency Changes to 105 CMR 170.000)
- Copy of staff memorandum dated November 10, 2010 on the Request for Approval of Informational Bulletin on Annual Adjustments to Determination of Need Expenditure Minimums with Exhibits A & B (Annual Adjustments to Determination of Need Expenditure Minimums for capital costs and operating costs)
- Hospital Personnel Seasonal Influenza Vaccination Report 2009-2010 dated November 2010 with a copy of the PowerPoint slide Presentation
- Copy of PowerPoint slides on Presentation entitled, "New DPH Initiative to Promote Regional Delivery of Local Public Health"

The meeting adjourned at 12:00 p.m.

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John Auerbach, Chair

LMH